IV. APPEALS

When a requesting provider disagrees with the modification or denial of a prior authorization request, an administrative review may be requested. An administrative review is an independent, objective review of the information submitted with the initial request, as well as any additional documentation submitted with the request for administrative review.

A. Letters of Intent

1. An administrative review request must be postmarked or faxed within seven working days of the receipt of modification or denial, by the provider who requested the prior authorization.
2. If the service in question is an inpatient hospitalization, and the patient remains hospitalized, the provider may submit a Letter of Intent to Request an Administrative Review. This letter signifies that the provider intends to request an administrative review upon the patient's discharge from the facility. The letter must be postmarked within the same seven day limitation as is cited in the rules governing the request for administrative review (405 IAC 5-7-2) and must be forwarded, in writing, to Health Care Excel.
3. Upon receipt, the letter of intent will be forwarded to the HCE hearings and appeals staff. The hearings and appeals support specialist will stamp the date the document is received, attaching the envelope for proof of timely submission.
4. The prior authorization specialist will complete a letter of acknowledgment, and mail the letter to the provider. The letter will contain a listing of documentation needed to conduct the review as well as the time limit for the submission of the requested information. Refer to **Exhibit IV-13**. The PA specialist will enter the following information into the hearings and appeals log.

    - Recipient Identification (RID) Number.
    - Member name.
    - Prior Authorization (PA) number.
    - Provider number.
    - Type of service.
    - Procedure code(s) being appealed.
    - Cost per unit.
    - Number of units requested.
    - Number of units denied.
    - Dollars originally approved.

- Dollars originally denied.
- Date Letter of Intent received.
- Date Letter of Intent acknowledged.

5. The letter of intent to file an administrative review will be filed alphabetically by the last name of the member and used as proof of timely filing, should that become an issue of the appeal.

B. Administrative Review

1. The request for an administrative review (AR) will be forwarded to the prior authorization specialist.
2. The request must be forwarded in writing or 278 electronic transaction to HCE (telephone requests will not be accepted). The support specialist will stamp the request with the date received, and attach the envelope to the request for verification of postmark or authorized mail date.
3. The support specialist will copy the paper or faxed request for prior authorization and all documentation originally received. This information will be attached to the request for administrative review, and placed in a folder labeled with the member's name and Recipient Identification Number (RID).
4. The PA specialist will enter the following information into the tracking log (if it has not already been entered from a Letter of Intent to Request an Administrative Review).

- Recipient Identification (RID) number.
- Member name.
- Prior Authorization (PA) number.
- Provider number.
- Type of service.
- Procedure code(s) being appealed.
- Cost per unit.
- Number of units requested.
- Number of units denied.
- Dollars approved on the original request.
- Dollars denied on the original request.
- Date intent letter received (if appropriate for the administrative review).
- Date intent letter acknowledged (if appropriate for the administrative review*).*
- Date Administrative Review request received.

5. The prior authorization specialist will evaluate the AR request to ensure that it was submitted by the provider who submitted the original prior authorization request. The prior authorization specialist will assess the request to ensure that it was submitted within the required seven day limitation by counting 13 working days from the mailing date of the original decision letter to allow for mail delivery. If the AR request is untimely, a notification letter explaining the reason for the denial will be sent and Indiana*AIM* will be updated to reflect the decision and the reason for the decision. (Refer to **Exhibit IV-11**.)

6. The prior authorization specialist will evaluate the submitted documentation. If further information is needed, a letter requesting additional documentation will be sent (refer to **Exhibit IV-10**). The request will be held for 30 calendar days following the request for additional documentation. If no documentation is received, the denial or modification will be upheld. If information is received, the review will be completed within seven business days of receipt of the additional information.

7. If new documentation brings the request into compliance with established criteria, the IAC requirements, IHCP bulletins or banners, or other directives by the Office of Medicaid Policy and Planning, the request will be approved by the prior authorization specialist. (The denial or modification is overturned.)

8. If criteria are still not met, the prior authorization specialist will select a consultant type to whom to refer the case. This consultant may be the Medical Director or another physician, but may not be the same person who made the original denial or modification of the request.

9. The prior authorization specialist will initiate the Administrative Review/Hearings and Appeals Review, Consultant Referral Form. The PA specialist will forward all of the case documentation to the designated support specialist, who will forward the case materials to the selected consultant via overnight mail or fax, if the consultant is not anticipated to be available in the HCE offices.

10. The consultant will review the entire case documentation, render a decision, complete the Administrative Review/Hearings and Appeals Review, Consultant Referral Form., and return it to the designated support specialist via overnight mail or fax. The designated support specialist will forward the decision to the prior authorization specialist.

11. Within seven business days of the receipt of the request (or the receipt of the additional documentation requested) the prior authorization specialist will review all the documentation and issue a determination notice to the requesting provider and the member. The notice will contain the determination, the rationale for the decision, and the provider and member appeal rights.

12. The Indiana*AIM* system should be updated in the following manner.

    - Enter Indiana*AIM*.
    - Click "Prior Authorization."
    - Enter prior authorization number in "Inquire PA Number" block.
    - Click "inquire."
    - Click "Admin Review" box.
    - Enter requested information, including dates received and mailed.
    - Save and exit.
    - Click on "Line Item."
    - Change units, dates or decision to match administrative review decision.
    - Save and exit.
    - Click on "New IAC/Text."
    - Enter any laws utilized in making the administrative review decision as well as any narrative to be read by the provider or the member.
    - Save and exit.
    - Click on "Internal Text."
    - Enter name of appellant, if a consultant reviewed the case, the AR decision, and the initials of the staff writing and sending the letter.
    - Save and exit.
    - Click on "Batch" for automatic batch mailing to the provider and member, or click on "online text" for online printing and mailing with the letter by prior authorization specialist.
    - Exit all.

13. The prior authorization specialist will update the tracking log (in Access) with the new information regarding the administrative review decision, action, dollars, etc.

14. The designated support specialist will file the case according to the decision and date. For example, all approved decisions are filed by date, and are forwarded to long-term storage for eventual destruction in compliance with the Approved Records Retention and Disposition schedule. All modified and denied decisions are filed by date and kept in close proximity to the hearings and appeals area until such time as a hearing is requested, or until the time frame for the filing of the appeal for a hearing has expired.

    After the time for further appeal has expired, the case will be moved to long-term storage for destruction in compliance with the approved Records Retention and Disposition Schedule.

    Note:

    - A prior authorization request will be "suspended" when insufficient information is submitted to render a decision. A suspension is not a final decision on the merits of the request and is not subject to appeal. A "suspended" request may be resubmitted with additional information (405 IAC 5-7-1).

    - Any administrative review request that is not reviewed and a decision made, within seven (7) business days will be automatically approved, unless approval is in direct conflict with a published law or rule.

    Refer to **Table IV-1,** (Administrative Review of a Modified or Denied Prior Authorization Decision), **Figure IV-1,** (Indiana*AIM* Windows), and **Figure IV-2** (Administrative Review Procedure flow chart) for detailed instructions on completion of an administrative review.

TABLE IV-1

PROCEDURE/PROCESS: ADMINISTRATIVE REVIEW OF A MODIFIED OR DENIED PRIOR AUTHORIZATION DECISION

No.	Description of Activity	Responsible Party
1.	A requesting provider wishing to appeal a PA decision must initiate a request for administrative review to HCE within seven days from the date the decision was received.	Requesting Provider
2.	The HCE prior authorization specialists will re-evaluate all of the information submitted (as well as any additional information requested by HCE) within seven business days of the receipt of all the information necessary to conduct the review.	Prior Authorization Specialist
3.	If it is not possible to approve the request, a consultation is sought with the Medical Director or a consultant, by phone or in person.	Prior Authorization Specialist & Medical staff
4.	A decision is made based on medical necessity and the submitted documentation.	Prior Authorization Specialist & Medical staff
5.	The decision is entered into Indiana*AIM* by the prior authorization specialist, who also completes the appropriate administrative review response letter and mails the letter to the requesting provider and member.	Prior Authorization Specialist
6.	If the provider is appealing the denial of continued hospitalization, and the member is still hospitalized, the provider must submit a letter of "Intent to file an Administrative Review" within the same time limits as noted in #1.	Requesting Provider
7.	After filing a Letter of Intent, the requesting provider has 45 days following the member's discharge from the facility in which to submit the entire medical record and the request for administrative review.	Requesting Provider
8.	If the provider disagrees with the administrative review decision, he/she may submit a request for an administrative appeal. (See ALJ hearing.)	Requesting Provider
9.	Once the decision has been made, each case is filed by the type of decision and the date of the decision in the administrative review files.	Support Specialist

FIGURE IV-1

WINDOW: PA ADMINISTRATIVE REVIEW

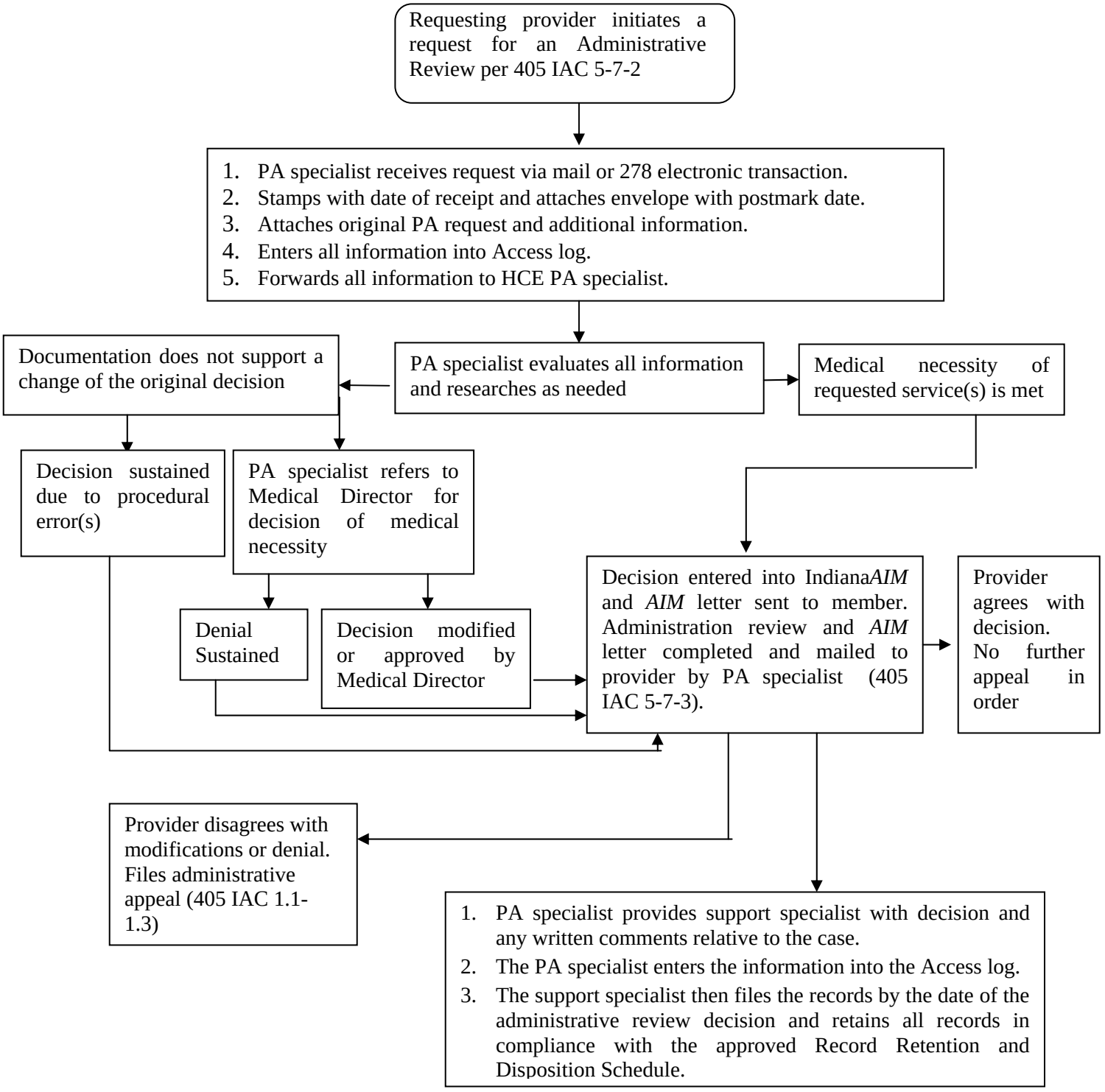
Received Date: The date in CCYYMMDD format that an Administrative Review is received by the hearings and appeals support specialist.

Mailed Date: The date in CCYYMMDD format that the appeal is printed.

See page IV-4, item 12, for information to be entered in internal text.

FIGURE IV-2

ADMINISTRATIVE REVIEW PROCEDURE



C. Administrative Appeal

An Administrative Law Judge (ALJ) hearing is a mechanism for providers and members to appeal any modified or denied prior authorization decision. All procedures surrounding administrative appeals are governed by the Indiana Administrative Code, 405 IAC 1.1-1.3 (Appeal Procedures for Applicants and Members of IHCP). Instructions for appealing are included with each prior authorization decision mailed to the requesting provider and to the member.

It is the responsibility of the PA reviewers, consultants, hearings and appeals staff, and Medical Director to provide an impartial review of all submitted documentation and information, as well as all documents and testimony provided during the hearing. This will ensure the appealed decisions meet the rules set forth in the Indiana Administrative Code and any internal criteria or directives from OMPP.

A Medicaid **provider** is entitled to an administrative appeal if an administrative review was requested first (405 IAC 1.1-1.3). If the provider is dissatisfied with the administrative review decision, a request for an Administrative Law Judge hearing may be filed. The request must be forwarded in writing to the Indiana Family and Social Services Administration (FSSA) within 30 days, plus three days mail time, of receipt of the administrative review decision as outlined in 405 IAC 5-7.

A **member** need not request an administrative review prior to requesting an administrative hearing. In compliance with 405 IAC 1.1-1.3, the member's request for administrative hearing must be forwarded in writing to FSSA within 30 days, plus three days mail time, of receipt of the initial prior authorization decision form. The member's caseworker may utilize the form provided by the State to assist the member in filing the appeal, or the member may send the appeal directly to the FSSA.

Either the provider or the member must submit requests for an administrative hearing before an Administrative Law Judge to the following address.

MS04
Indiana Family and Social Service Administration
Division of Family and Children
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

After the FSSA hearings and appeals staff receives the hearing request, HCE will be contacted to supply the issues surrounding the request, e.g., the service requested, the decision, and the rationale for that decision. If the appeal is for a prior authorization request that was approved, the State is notified and the appeal is dismissed.

If the appeal is appropriate, FSSA schedules the administrative hearing. All hearings for provider appeals are held at the Indiana Government Center South, and all hearings for member appeals are held at the County Division of Family and Children in the member's county of residence. Only in special situations will the hearing be held at the member's place of residence, or be conducted via telephone.

Prior to the hearing, all cases are reviewed by the HCE hearings and appeals staff and the Medical Director, if needed.

1. The PA specialist locates any previously submitted documentation relating to the appeal.

2. The PA specialist assesses the documentation and compares this to the IAC rules, relevant IHCP Provider Bulletins, Banner pages, internal criteria, and verbal directives from the OMPP, where applicable.

   Appeals filed for a service that is a continuing service, e.g., home health care, therapies or outpatient psychiatric care, must be given special and immediate consideration. Due to a previous court decision, these types of services must be "restored" to the level of the previous authorization period when the member files an appeal within 10 days of receipt by the member of the decision to modify or deny the requested service(s).

   For example, the member has been receiving 40 hours of home health weekly.

   - ♦ The provider submits a request for continuation of the services at 40 hours weekly to begin 6/1/02.

The decision is made on 5/15/2002 to approve 40 hours per week from 6/1/2002 to 7/1/2002, and then reduce the hours to 20 hours per week beginning on 7/1/2002.

The member receives the prior authorization decision letter on 5/20/2002, informing him or her of the reduction or termination of services.

- If the member files an appeal prior to the effective date (7/1/2002), even if it is after the beginning of the PA period (6/1/2002), services **must** be restored to the level at which they were approved during the authorization period previous to the period which is being appealed, if the member files the appeal within 10 days of the mailing of the notice of action and the action is not a result of the application of state or Federal Law 942 CFR 431.231 © (1, 2, 3).

- Once HCE is made aware of this appeal, services must be restored to the previously authorized level (40 hours weekly) so there is no reduction in the provided services until the case can be reviewed, a hearing held, and a decision rendered.

- If the ALJs decision is in favor of the State, the reinstated services are reduced to the level designated by the ALJ.

- If the appeal is withdrawn, or the member fails to appear for the scheduled hearing, the reinstated services are reduced to the level originally approved on that PA request.

3. If additional information has been provided which justifies the request for services or supplies, the prior authorization decision may be changed to approved, or modified, if supported by the additional information.

4. The appellant is notified, verbally or in writing, of the option to withdraw the appeal, since the issue of the appeal has been resolved to the satisfaction of all parties involved.

5. If the appeal is resolved prior to the scheduled hearing, the PA Specialist notifies the FSSA, both verbally and in writing, that the issue has been resolved.

6. After updating the Indiana*AIM* system, duplicate letters and decision forms are prepared and mailed to both the provider and member. Since the case has been resolved, there will be no further action, and the file can be forwarded for long-term storage.

7. If no agreement can be reached, the hearing will be held as scheduled.

8. The role of the HCE PA specialist is to prepare and present the case at the hearing as a representative of the State. The hearing packet must accurately reflect all pertinent information relating to the medical necessity of the issue(s) being appealed.

   Applicable citations of the Indiana Administrative Code, or any other laws, and all other documentation used in the decision-making process will be included in the appeal packet. The Medical Director may also attend selected hearings to present medical testimony and respond to medical questioning.

   Contents of the hearings and appeals packet should include the following items, if appropriate to the service being appealed.

   - A letter of rationale detailing the reasons for the initial decision in a clear and concise manner. (refer to **Exhibit IV-25.**)
   - A copy of the notification of the scheduled hearing.
   - A copy of the appellant's letter requesting the hearing.
   - A copy of the history and physical.
   - A copy of the physicians' progress notes.
   - A copy of any psychological evaluation (if a mental health service).
   - A copy of the Certification of Need (if applicable).
   - A copy of the original request for prior authorization, and all attachments.
   - A copy of the Prior Authorization Decision Form.
   - A copy of the request for Administrative Review (if applicable).
   - A copy of the HCE Administrative Review response (if applicable).
   - A copy of the prior authorization history.
   - A copy of the discharge summary, nurses' notes, and therapy notes, etc.
   - Copies of any criteria or documentation utilized at any point in the review process.
   - Any other documentation deemed necessary to facilitate an accurate decision.

9. Attendance at ALJ hearings held in the counties is at the discretion of the Prior Authorization Specialist, Prior Authorization Director, and the Medical Director. Factors taken into consideration are, the degree of medical involvement; the location of the hearing; multiple hearings on the same date and time; the cost-effectiveness of pursuing the issue; and the significance of the case in terms of setting precedence for future determinations of similar cases. Whenever feasible, HCE staff should attend the hearings.

10. The ALJ renders a decision based upon the information presented at the hearing. The decision must be rendered within 60 days of the appeal. If a continuance is granted for submission of additional evidence, the decision date is continued equally.

11. Following the hearing, the files, including all original documentation, are filed by member's last name under the title, "Awaiting Decision."

12. When the decision is received, the system is updated and a copy of the updated decision is mailed to both the member and the requesting provider. If either the member or requesting provider wishes to appeal the administrative hearing decision, instructions for requesting an agency review are included at the end of the administrative hearing decision notice.

13. Agency review requests must be submitted promptly to allow for the review to be conducted and the decision rendered before the 90-day limitation expires (per Gomolisky vs Davis, no decision may be rendered **after** 90 days from the date the original appeal was received by FSSA).

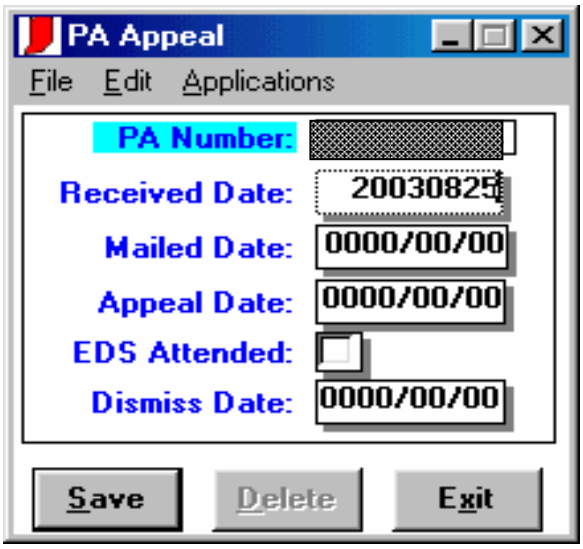
14. Hearing decisions approving all of the requested services are filed under "Hearings Approved". Hearing decisions approving only a portion of the requested service(s) or supply(s) are filed under the title, "Hearings Modified and Denied," since these may be appealed.

15. If no agency review is received within the stated time limit, the files are withdrawn and forwarded for long-term storage.

Refer to **Table IV-2**, (Administrative Law Judge Hearing process), and **Figure IV-4**, (Administrative Law Judge Hearing Procedure flow chart) for detailed instructions on review of ALJ hearings.

FIGURE IV-3

WINDOW: PA APPEAL



Received Date: The date in CCYYMMDD format that an Appeal is received from the FSSA Office of Hearing and Appeals by the PA department.

Mailed Date: The date in CCYYMMDD format that the appeal is printed.

Appeal Date: The date in CCYYMMDD format that FSSA scheduled the appeal hearing.

EDS Attended: An 'X' indicator to be flagged if an HCE representative attended the hearing.

Dismiss Date: The date in CCYYMMDD format if the appeal is dismissed.

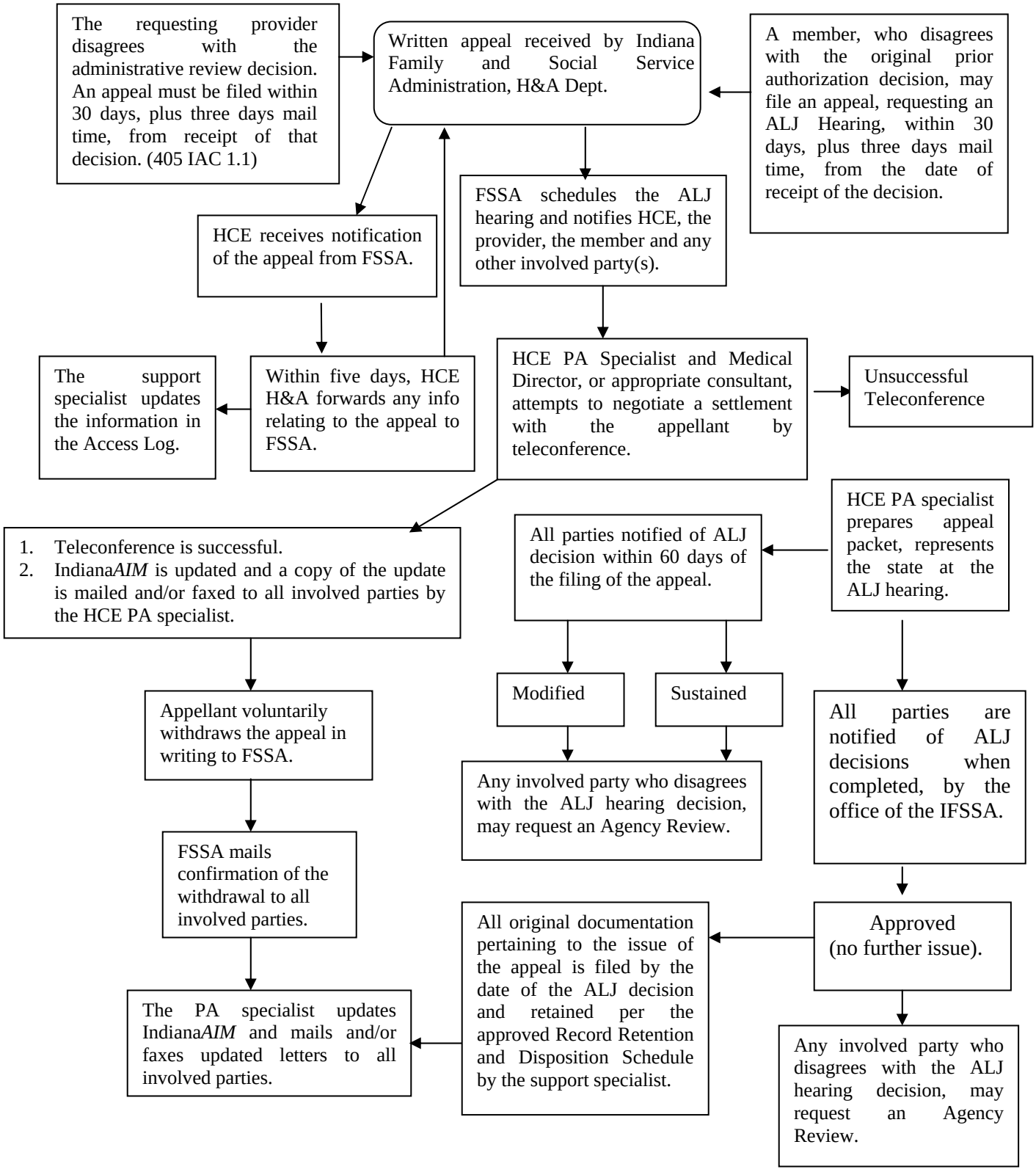
TABLE IV-2

PROCEDURE/PROCESS: ADMINISTRATIVE LAW JUDGE HEARING

No.	Description of Activity	Responsible Party
1.	When the requesting provider disagrees with the Administrative Review decision, or the member disagrees with the original PA decision, either or both may request an administrative appeal.	Requesting provider or member
2.	Either party must submit an appeal request to FSSA-Hearings and Appeals within 30 days, plus three days mail time, of receipt of the decision.	Requesting provider or member
3.	FSSA notifies HCE of the appeal and requests information regarding the issue to appeal from HCE.	FSSA Hearings and Appeals
4.	FSSA schedules the ALJ hearing and notifies in writing all parties involved. (Provider appeals are heard at the Indiana Govt. Center while member appeals are heard at the county Division of Family and Children in the member's county of residence.)	FSSA Hearings and Appeals
5.	HCE PA specialist attempts to resolve the appeal through teleconference(s) with the provider and/or member.	HCE Prior Authorization Specialist and/or medical staff.
6.	If issue(s) are resolved, the agreement is entered into Indiana*AIM*, and letters indicating the resolution are mailed to all involved parties, including FSSA.	HCE Prior Authorization Specialist
7.	If issue is resolved, the appellant must withdraw the appeal by notifying FSSA in writing.	Requesting provider or member
8.	Cases that cannot be resolved are prepared for hearing.	HCE Prior Authorization Specialist
9.	The facts are presented and the issues are argued at hearing.	HCE Prior Authorization Specialist
10.	A decision is issued within 60 days from the date the appeal was filed.	Administrative Law Judge
11.	ALJ decision issued.	Administrative Law Judge
12.	Indiana*AIM* is updated to comply with ALJ decisions and updates are mailed to all involved parties.	HCE Prior Authorization Specialist
13.	Cases are filed according to decision and date of decision.	HCE Hearings and Appeals Support Specialist
14.	If any party disagrees with the ALJ decision, an agency review may be requested.	Any involved party

FIGURE IV-4

ADMINISTRATIVE LAW JUDGE HEARING PROCEDURE



D. Agency Review

The member, the provider, or HCE may appeal the administrative hearing decision by requesting an Agency Review. This is the last step before judicial review.

The HCE staff may not submit new documentation. If HCE chooses to provide any input, a "memorandum of law" may be submitted to the hearings and appeals department at the State, to be presented at the agency review. Copies are provided to all involved parties.

1. Following receipt of the agency review decision, the Indiana*AIM* system is updated, as is the Access log.

2. A copy of the Indiana*AIM* decision letter is mailed to both the member and the provider.

3. The decision is placed in the case file under the title, "Agency Review Decisions" by the member's last name. These files can be kept in the long-term storage facility, but apart from all other records. In the event that either the member or the provider should appeal this decision by requesting a Judicial Review, it may be necessary to access these records up to four years after the date of the agency review. Therefore, it is imperative that all files for which an agency review was requested are readily accessible.

   HCE retains all original documents. Only copies of documents are included in any appeal packet or documentation otherwise forwarded to any entity. All records for appealed services are filed by the hearings and appeals support specialist, and destroyed only after the time limit has expired for any future appeal.

Refer to **Exhibits IV-1** through **IV-25,** for examples of review letters applicable to appeals.

EXHIBIT IV-1

Administrative Review Letter #1
Decision Modified

Date

Address

Re:
RID:
PA #:
Dates of Service:

Dear:

This is in response to your request for an Administrative Review for the above-named member. The Indiana Administrative Code (IAC), 405 IAC 5-3-11 (4), stipulates that the Office's decision will be based upon medical necessity as determined by current professional standards commonly held to be applicable to the case; review of criteria set out in the IAC; medical and social information provided on the request form or documentation accompanying the request form; and an individual case-by-case review of the request.

Administrative review by _____ finds _____. Therefore, our original decision has changed to approve a portion of the service(s) requested. Enclosed is the updated Prior Authorization decision letter that will also be sent to the member.

The Indiana Administrative Code, 405 IAC 5-7-1, stipulates that a member or provider may appeal the modification or denial of any Indiana Health Coverage Programs (IHCP) covered service. The member may request an Administrative Hearing without first requesting an Administrative Review.

After exhausting the Administrative Review remedies, a provider may request an Administrative Hearing. Attached to the provider's request for hearing should be the following documentation:

1. A letter summarizing the requested services, the member's name, the RID (Recipient Identification Number) and Prior Authorization number.
2. Documentation, including any pertinent medical records, consultations, or other records to support the appellant's case, not previously submitted
3. A copy of the Prior Authorization form (if applicable).

Exhibit IV-1 – continued

Either request must be in writing, and mailed to the following address within thirty (30) days, plus three (3) days mailing time, of the receipt of the notice of the Administrative Review decision.

MS04
Indiana Family and Social Services Administration
Division of Family and Children
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Medical Director
Indiana Medical Policy and Review Services

Enclosure

EXHIBIT IV-2

Administrative Review Letter #2
Decision Approved

Date:

Address:

Re:
RID:
PA #:
Dates of Service:

Dear:

This is in response to your request for an Administrative Review for the above-named member. The Indiana Administrative Code (IAC), 405 IAC 5-3-11 (4), stipulates that the Office's decision will be based upon:

- medical necessity as determined by current professional standards commonly held to be applicable to the case
- review of criteria set out in the IAC
- medical and social information provided on the request form or documentation accompanying the request form
- and an individual case-by-case review of the request.

The submitted documentation has been reviewed by Health Care Excel staff. After review of the documentation submitted, the requested (services) have been approved. Enclosed is a copy of the Prior Authorization decision letter that will be mailed to the member.

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Director, Prior Authorization
Indiana Medical Policy and Review Services

Enclosure

EXHIBIT IV-3

Administrative Review Letter #3
Decision Upheld

Date

Address

Re:
RID:
PA #:
Dates of Service:

Dear:

This is in response to your request for an Administrative Review for the above-named member. The Indiana Administrative Code (IAC), 405 IAC 5-3-11 (4), stipulates that the Office's decision will be based upon medical necessity as determined by current professional standards commonly held to be applicable to the case; review of criteria set out in the IAC; medical and social information provided on the request form or documentation accompanying the request form; and an individual case-by-case review of the request.

Administrative Review by a *(insert specialty)* consultant finds *(insert decision text)*. Therefore, the original decision has been reaffirmed. Enclosed is a copy of the Prior Authorization decision letter that will be mailed to the member.

The Indiana Administrative Code, 405 IAC 5-7-1, stipulates that a member or provider may appeal the modification or denial of any Medicaid covered service. The member may request an Administrative Hearing without first requesting an Administrative Review.

After exhausting the Administrative Review remedies, a provider may request an Administrative Hearing. Attached to the provider's request for hearing should be the following information:

1. A letter summarizing the requested service(s), the member's name, Recipient Identification Number (RID), and Prior Authorization (PA) number.

2. Documentation, including any pertinent medical records, consultations, or other records to support the appellant's case, not previously submitted.

3. A copy of the PA form (if applicable).

Either request must be in writing, and mailed to the following address within thirty (30) days of the receipt of the notice of the Administrative Review decision.

EXHIBIT IV-3 – continued

MS04
Indiana Family and Social Services Administration
Division of Family and Children
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Medical Director
Indiana Medical Policy and Review Services

Enclosure

EXHIBIT IV-4

Administrative Review Letter #4
Psychiatric Admission – Late Submission of Certification of Need

Date

Address

Re:
RID:
PA #:
Admission Date:

Dear:

This letter is in response to your request for an Administrative Review of the *(insert description)* of services for the above-named member. Our medical staff has reviewed your request and has reaffirmed the original decision.

The Indiana Administrative Code (IAC), 405 IAC 5-20-5, stipulates that Indiana Health Coverage Programs (IHCP) reimbursement is available for mental health services provided in an inpatient psychiatric facility only when the member's need for admission has been authorized. The authorization must be completed as follows.

1. By the attending physician or staff physician.

2. By telephone prior authorization review prior to admission for an individual who is a member of IHCP when admitted to the facility as a non-emergency admission, to be followed by a written Certification of Need (1261A) within ten (10) business days of admission.

3. By telephone prior authorization review within forty-eight (48) hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, to be followed by a written Certification of Need within fourteen (14) business days of admission. If the provider fails to call within forty-eight (48) hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, IHCP reimbursement shall be denied for the period from admission to the actual date of notification.

4. In writing, within ten (10) business days after receiving notification of an eligibility determination for individuals applying for IHCP while in the hospital, and covering the entire period for which IHCP reimbursement is being sought.

EXHIBIT IV-4 – continued

5. In writing, at least every 60 days after admission, or as requested by the state IHCP agency or its designee, to re-certify that the patient continued to require inpatient psychiatric hospital services.

The Indiana Administrative Code, 405 IAC 5-20-7, stipulates that IHCP reimbursement will be denied for any days during which the inpatient psychiatric hospitalization is found not to have been medically necessary, and if the required documentation is not submitted in compliance with the specified timeframes in accordance with the provisions in 405 IAC 5-20-5.

The member was admitted *(insert date)*. The Certification of Need (1261A) was signed by the physician on *(insert date)*, and received by HCE on *(insert date)*. This exceeds the allotted time limit. Therefore, the entire hospital stay has been denied.

The Indiana Administrative Code, 405 IAC 5-7-1, stipulates that a member or provider may appeal the modification or denial of any Medicaid covered service. The member may request an Administrative Hearing without first requesting an Administrative Review.

The Indiana Administrative Code, 405 IAC 5-7-2, stipulates that a provider must request an administrative review of denial or modification of a prior authorization decision before filing an appeal under 405 IAC 1-1. The provider who submitted the initial prior authorization request must initiate an administrative review request within seven (7) working days of the receipt of modification or denial. The request must be forwarded, in writing, to the contractor; telephone requests will not be accepted.

After exhausting the Administrative Review remedies, a provider may request an Administrative Hearing. Attached to the provider's request for hearing should be the following documentation.

1. A letter summarizing the requested services, the member's name, Recipient Identification (RID) number and Prior Authorization number.

2. Documentation, including any pertinent medical records, consultations, or other records to support the appellant's case, not previously submitted.

3. A copy of the Prior Authorization form (if applicable).

Either request must be in writing, and mailed to the following address within 30 days of the receipt of the notice of the administrative review decision.

EXHIBIT IV-4 – continued

MS04
Indiana Family and Social Services Administration
Division of Family and Children
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Director, Prior Authorization
Indiana Medical Policy and Review Services

EXHIBIT IV-5

Administrative Review Letter #5
The Member was Eligible on Dates of Service
Request for Retroactive Authorization Denied

Date

Address

Re:
RID:
PA #:

Dear:

This is in response to your request for an Administrative Review for the above-named member. The Indiana Administrative Code (IAC), 405 IAC 5-3-7 states, "The provider assumes responsibility for verifying the member's eligibility on the service date."

The Indiana Administrative Code 405 IAC 5-3-9 provides the circumstances under which prior authorization will be given after services have begun or supplies have been delivered. These are: (1) pending or retroactive member eligibility. The prior authorization request must be submitted within twelve (12) months of the date of the issuance of the member's Indiana Health Coverage Programs (IHCP) card. (2) Mechanical or administrative delays or errors by the contractor or county office of family and children. (3) Services rendered outside Indiana by a provider who has not yet received a provider manual. (4) Transportation services authorized under 405 IAC 5-30. The prior authorization request must be submitted within twelve (12) months of the date of service. (5) The provider was unaware that the member was eligible for services at the time services were rendered. Prior authorization will be granted in this situation only if the following conditions are met:

(A) The provider's records document that the member refused or was physically unable to provide the member identification (RID or IHCP) number.

(B) The provider can substantiate that the provider continually pursued reimbursement from the patient until IHCP eligibility was discovered.

(C) The provider submitted the request for prior authorization within sixty (60) days of the date IHCP eligibility was discovered.

The submitted records indicate the services were provided starting *(insert date)*. This member was eligible on this date. Prior authorization was not requested until *(insert date)*. There is no indication any of the exceptions listed in the Indiana Administrative Code have been met. Therefore, the previous denial is reaffirmed.

EXHIBIT IV-5 – continued

The Indiana Administrative Code, 405 IAC 5-7-1, stipulates that a member or provider may appeal the modification or denial of any IHCP covered service. After exhausting the Administrative Review remedies, a provider may request an Administrative Hearing.

Attached to the provider's request for hearing should be the following information:

1. A letter summarizing the requested service(s), the member's name, Member Identification Number (RID) and Prior Authorization (PA) number.

2. Documentation including any pertinent medical records, consultations, or other records to support the appellant's case (not previously submitted).

3. A copy of the Prior Authorization form, if applicable.

Based on 405 IAC 1.1-1-3, either request must be in writing and mailed to the following address within thirty-three (33) days of the receipt of the Administrative Review decision.

MS04
Indiana Family and Social Services Administration
Division of Family and Children
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Director, Prior Authorization
Indiana Medical Policy and Review Services

Enclosure

EXHIBIT IV-6

Administrative Review Letter #6
Appeal Resolved Prior to Scheduled Hearing

Date

MS04
Hearing Supervisor
State of Indiana Family and Social Services Administration
Division of Family and Children
402 West Washington Street, Room W392
Indianapolis, IN 46204

Recipient:
RID:
PA #:

Dear:

The issue(s) surrounding the appeal filed on behalf of the above-named member has been resolved. Please dismiss the appeal.

Date of scheduled hearing:
Place of scheduled hearing:
HCE Approved:

Enclosed is the updated decision form reflecting the approval and updates made to Indiana*AIM*. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4500.

Sincerely,

(Name and credentials of specialist)
Prior Authorization Specialist
Indiana Medical Policy and Review Services

Enclosure(s)

EXHIBIT IV-7

Administrative Review Letter #7
Delinquent Submission Following 30 Day Suspension

Date

Address

Re:
RID:
PA #:

Dear:

This is in response to your request for an Administrative Review for the above-named member. Our records show that the request for prior authorization was submitted within the designated time limitations. A decision could not be rendered based on the information provided. Additional information was requested. You were notified that 30 days would be allowed for the submission of the requested information. If the requested information was not received within the 30 day limitation, the request would be denied.

Our records show this decision was made on *(insert date).* The decision letter was mailed to you and to the member on the following business day. The submitted information was received in our offices on *(insert date).* This exceeds the stated time limitation. Therefore, your request remains denied.

The Indiana Administrative Code (IAC), 405 IAC 5-7-1, stipulates that a member or provider may appeal the modification or denial of any Indiana Health Coverage Programs (IHCP) covered service. After exhausting the Administrative Review remedies, a provider may request an Administrative Hearing.

Attached to the provider's request for hearing should be the following information:

1. A letter summarizing the requested service(s), the member's name, Member's Identification Number (RID) and Prior Authorization number.

2. Documentation including any pertinent medical records, consultations, or other records to support the appellant's case (not previously submitted).

3. A copy of the Prior Authorization form, if applicable.

Based on 405 IAC 1.1-1.3, either request must be in writing and mailed to the following address within thirty (30) days, plus three (3) days mailing time, of the receipt of the Administrative Review decision.

Exhibit IV-7 – continued

MS04
Indiana Family and Social Services Administration
Division of Family and Children
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Director, Prior Authorization
Indiana Medical Policy and Review Services

Enclosure

EXHIBIT IV-8

Administrative Review Letter #8
More than One Year Elapsed from Enrollment in Medicaid

Date

Name
Address
City, State, Zip

Recipient:
RID:
PA#:
Date(s) of service:

Dear:

This letter is in response to your request for an Administrative Review of the decision made by Indiana Health Coverage Programs (IHCP) for the above-named member. Our medical staff has reviewed the request and the (modification/denial) of services has been reaffirmed.

Indiana Administrative Code (IAC), 405 IAC 5-3-9, stipulates authorization for payment will be given after services have begun or supplies have been delivered under certain circumstances. One of those circumstances is pending or retroactive member eligibility. The prior authorization request must be submitted within one year from the date eligibility is established or within 60 days of the date IHCP eligibility was discovered. The same standards will be applied as would have been applied if the authorization had been requested before the provision of services or supplies. The prior authorization request may request services or supplies retroactively for up to one year from the date the member was enrolled.

Our records indicate this member was enrolled on (*insert date)*. The request for prior authorization was received on *(insert date)*. Since more than one year from the enrollment has elapsed, your request is considered untimely and cannot be honored.

If you disagree with this denial, you have the right to appeal pursuant to 470 IAC 1-4. Your request must be in writing and filed within thirty (30) days, plus three (3) days mailing time, of the receipt of this letter. Such an appeal must be mailed to the following address.

MS04
Indiana Family and Social Services Administration
Division of Family and Children
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Exhibit IV – 8 – continued

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Director, Prior Authorization
Indiana Medical Policy and Review Services

EXHIBIT IV-9

Administrative Review Letter #9
Late Administrative Review Request Following Denied Certification of Need

Date

Recipient:
RID:
PA#:
Admission Date:

Dear:

This letter is in response to your request for an Administrative Review of the decision made by Indiana Health Coverage Programs (IHCP) for the above named member. The Indiana Administrative Code (IAC), 405 IAC 5-7-2 (b), states, "An administrative review request must be initiated within seven working days of the receipt of modification or denial by the provider who submitted the prior authorization request. The request must be forwarded in writing to the contractor; telephone requests will not be accepted."

The Certification of Need (1261A) was denied by IHCP on *(insert date)* and mailed on or about *(insert date)*. With three days added for delivery of first class U.S. mail, you had a total of 10 days to initiate a request for Administrative Review by filing your request on or before *(insert date)*. Your request was postmarked on *(insert date)* and delivered on *(insert date)*. This exceeds the allotted time period for initiation of an Administrative Review. Therefore, we are unable to consider your request.

If you disagree with this determination regarding your request for Administrative Review, you have the right to appeal pursuant to 470 IAC 1-4. Your request must be in writing and filed within thirty (30) days, plus three (3) days mailing time, of the receipt of this letter. Such an appeal must be mailed to the following address.

MS04
Indiana Family and Social Services Administration
Division of Family and Children
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Exhibit IV-9 – continued

Should you request reconsideration of this denial of review; the issue at a hearing will be whether you qualify under 405 IAC 5-7-2 (b) to obtain review of the original prior authorization decision.

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Director, Prior Authorization
Indiana Medical Policy and Review Services

EXHIBIT IV-10

Administrative Review Letter #10
Request for Additional Information

Date:

Address:

Re:
RID:
PA#:
Dates of Service:

Dear:

This is in response to your request for an administrative review of the decision made by Indiana Health Coverage Programs (IHCP) for the above-named member. We have received the documentation mailed to us. However, in order to conduct the review, the following additional information is requested.

- *(List each document needed)*

The Indiana Administrative Code (IAC), 405 IAC 5-7-3 (b) and (c), stipulates that the administrative review will assess medical information pertinent to the case in question and the review decision of the IHCP contractor will be rendered within seven (7) working days of request. The time limit for issuance of a decision does not commence until the provider submits a complete request, including all necessary documentation required by the contractor to render a decision.

This appeal will be held for 30 calendar days, awaiting the requested information. Failure to comply by submitting the requested information will result in a denial of your request for administrative review.

Thank you in advance for your prompt attention to this request. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

(name and credentials of Specialist)
Prior Authorization Specialist
Indiana Medical Policy and Review Services

EXHIBIT IV-11

Administrative Review Letter #11
Untimely Administrative Review Request

Date

Address

RE:
RID:
PA#:
Dates of Service:

Dear:

Pursuant to Indiana Administrative Code (IAC) 405 IAC 5-7-2, you have requested an administrative review of the prior authorization decision for the above-named member. This law states the request must be initiated within seven (7) days (plus three (3) days for mail) from the date the modification or denial is received by the provider or member.

Our records show this denial was made on *(insert date)*. Your request for administrative review was received in our office *(insert date)*. This exceeds the time limit as specified in the Indiana Administrative Code.

Pursuant to 405 IAC 5-7-2(a), you may file an appeal of this decision under 405 IAC 1.1-1.3. Your appeal request must be filed in writing within thirty (30) days, plus three (3) days mailing time, from the date on this letter. Please mail your appeal request to:

MS04
Indiana Family and Social Services Administration
Division of Family and Children
402 West Washington Street, Room W392
Indianapolis, Indiana 46204
Attention: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Director, Prior Authorization
Indiana Medical Policy and Review Services

EXHIBIT IV-12

Administrative Review Letter #12
Response to Letter of Intent to File an Administrative Review

Date

Address

Re:
RID #:
PA #:
Dates of Service:

Dear:

This is in response to your Letter of Intent to File an Administrative Review, received in our office on *(insert date)*. The issue is that of the decision made by Indiana Health Coverage Programs (IHCP) for the above-named member. The Indiana Administrative Code (IAC), 405 IAC 5-7-3 (b) and (c), stipulates the review will assess medical information pertinent to the case in question and the review decision of the IHCP contractor will be rendered within seven (7) business days of the request. The time limit for issuance of a decision does not commence until the provider submits a complete request, including all necessary documentation required to render a decision.

The entire medical record is needed for all inpatient hospitalizations, including acute care, psychiatric and rehabilitation hospitalizations. The submitted documentation must include the **typed physician's discharge summary**, therapy notes, mental health commitment documentation, and documentation of referral to Child Protective Services, including notification from the County Division of Family and Children indicating an investigation was conducted and completed.

All pertinent documentation must be submitted to Health Care Excel within forty-five (45) calendar days of discharge. **Failure to comply will result in a denial of your request for administrative review.** Please submit the required documentation so that we may review the request.

Thank you for your cooperation. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

(name and credentials of specialist)
Prior Authorization Specialist
Indiana Medical Policy and Review Services

EXHIBIT IV-13

Administrative Review Letter #13
Denied Untimely Request – No Letter of Intent

Date

Address

Re:
RID:
PA #:
Dates of Service:

Dear:
This is in response to your request for an administrative review of the decision made by Indiana Health Coverage Programs (IHCP) for the above-named member. Your request has been denied because of the late submission of the request. The Indiana Administrative Code (IAC), 405 IAC 5-7-2 (b), stipulates that an administrative review request must be initiated within seven (7) business days of the receipt of modification or denial by the provider who submitted the prior authorization request.

Our records indicate the Prior Authorization Decision form was mailed or faxed to you on *(insert date)*. Allowing three (3) additional days for delivery of first class United States mail, you had a total of ten (10) days to initiate your request for administrative review. If you did not make the request because the member had not yet been discharged from your facility, a Letter of Intent to Request an Administrative Review must have been filed within the allowed ten (10) days. Once the letter of intent has been submitted, you are allowed an additional forty-five (45) calendar days from the date of discharge in which to submit the entire medical record along with your request for administrative review.

If the letter of intent had been received, your request would not be viewed as untimely. However, we have no letter of intent on file for this prior authorization decision. Your request for administrative review is postmarked *(insert date)* and was received on *(insert date)*. This exceeds the time limit for the initiation of an administrative review.

If you disagree with this determination, you have the right to appeal pursuant to 470 IAC 1-4. Your request must be filed, in writing, within thirty (30) days from the receipt of this letter and mailed to the following address.

Exhibit IV-13 – continued

MS04
Indiana Family and Social Services Administration
Division of Family and Children
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Should you request reconsideration of this denial of administrative review; the only issue at a hearing will be whether you qualify under 405 IAC 5-7-2 (b) to obtain an administrative review of the original prior authorization decision.

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

(name and credentials of Specialist)
Prior Authorization Specialist
Indiana Medical Policy and Review Services

EXHIBIT IV-14

Administrative Review Letter #14
Administrative Review Request Submitted Untimely Following Inpatient Admission
Letter of Intent Filed

Date

Address

Re:
RID:
PA #:
Dates of Service:

Dear:

This is in response to your letter of intent to file an administrative review of the decision made by Indiana Health Coverage Programs (IHCP) for the above-named member's above admission. Your letter of intent was received on *(insert date)*. The medical records department at your hospital indicates the member was discharged from your facility on *(insert date)*. As of today's date, no medical records have been received. This exceeds the allowed time period (45 calendar days after discharge) for submission of the complete chart for review. Therefore, we are unable to consider your request.

If you disagree with this determination, you have the right to appeal pursuant to 470 IAC 1-4. Your request must be filed in writing, within thirty (30) days from the receipt of this letter and mailed to the following address.

MS04
Indiana Family and Social Services Administration
Division of Family and Children
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Should you request reconsideration of this denial of administrative review; the only issue at a hearing will be whether you qualify under 405 IAC 5-7-2 (b) to obtain an administrative review of the original prior authorization decision.

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

(name and credentials of specialist)
Prior Authorization Specialist
Indiana Medical Policy and Review Services

EXHIBIT IV-15

Administrative Review Letter #15
Denied Incorrect Requestor

Date

Address

Re:
RID:
PA #:
Dates of Service:

Dear:

This is in response to your request for an Administrative Review of the decision made by Indiana Health Coverage Programs (IHCP) for the above-named member. Your request cannot be processed for the following reasons: The Indiana Administrative Code (IAC), 405 IAC 5-3-10, stipulates that "prior authorization requests may be submitted by any of the following: doctor of medicine, doctor of osteopathy, dentist, optometrist, podiatrist, chiropractor, psychologist endorsed as a health service provider in psychology (HSPP), home health agency or hospital."

405 IAC 5-7-2 stipulates that an "administrative review request must be initiated by the provider who submitted the prior authorization request." Since your organization is not the provider that may request a prior authorization without a physician's signature, your organization does not meet the requirements to request an administrative review of the prior authorization decision.

Also, please note that 405 IAC 5-31-4 (3) states, "The cost of all medical and nonmedical supplies and equipment, which includes those items generally required to assure adequate medical care and personal hygiene of patients, is included in the nursing facility per diem." *(may be deleted if patient not in LTC facility)*

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

(name and credentials of specialist)
Prior Authorization Specialist
Indiana Medical Policy and Review Services

EXHIBIT IV-16

Administrative Review Letter #16
ALJ Hearing – Issue Resolved

Date:

Appellant's name
Appellant's address
Appellant's city/state/zip

Re:
RID:
PA#:
Date(s) of Service:

Dear:

This is to notify you that a teleconference was held on __/__/__ with _____ in an attempt to resolve the issue(s) of the appeal filed for the above-named member.

During this communication, it was agreed that the request for prior authorization of _____ be modified/approved. Therefore, we are approving ___additional units for dates of service __/__/__ to __/__/__.

If you agree with this decision, you may wish to withdraw your appeal. Your written request to withdraw must be mailed to the following address early enough that it will be received prior to the __/__/__ scheduled hearing date.

MS04
Indiana Family and Social Services Administration
Division of Family and Children
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

If you disagree with this determination, the hearing will proceed as scheduled.

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Medical Director
Indiana Medical Policy and Review Services

EXHIBIT IV-17

Administrative Review Letter #17
ALJ – Unable to Resolve Issue Prior to Hearing

Date:

Appellant's name:
Appellant's address:
Appellant's city/state/zip

Re:
RID:
PA#:
Date(s) of Service:

Dear:

This is to notify you that a teleconference was held on __/__/__ with _____in an attempt to resolve the issue(s) of the appeal filed for the above-named member.

During this communication we were unable to reach an agreement. Therefore, no additional units are being authorized, and the Administrative Law Judge hearing scheduled for __/__/__ will be conducted.

If you should wish to withdraw the appeal, your written request to withdraw must be mailed to the following address early enough that it will be received prior to the scheduled hearing date.

MS04
Indiana Family and Social Service Administration
Division of Family and Children
402 W. Washington Street, W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

If you wish to proceed with the hearing, you must be either be present at the time of the hearing or request that the hearing be rescheduled. Please be advised that failure to appear at the scheduled hearing will result in dismissal of the appeal.

Exhibit IV-17 – Continued

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Medical Director
Indiana Medical Policy and Review Services

EXHIBIT IV-18

Administrative Review Letter #18
Required Information Not Received – Request Denied

Date:

Provider name
Provider address
Provider city/state/zip

Re:
RID:
PA#:
Dates of service:

Dear:

This is in response to your request for an administrative review of the decision made by Indiana Health Coverage Programs (IHCP) for the above-named member. Although your request for administrative review was received within the time limit required, the review could not be conducted because additional information was necessary in order to assess the medical information pertinent to the case.

A letter was mailed to you on *date* listing the requested information and also stating that your appeal would "be held for thirty (30) calendar days, awaiting the requested information. Failure to comply by submitting the requested information will result in a denial of your request for administrative review." As of this date, no information has been received in our office. Therefore, your request for administrative review has been dismissed and the decision remains unchanged.

If you do not agree with this decision, or if you mailed the requested information prior to the date of this letter, you may call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511 for further discussion or clarification. Thank you for your support of the Indiana Health Coverage Programs.

Sincerely,

(name and credentials of specialist)
Prior Authorization Specialist
Indiana Medical Policy and Review Services

EXHIBIT IV-19

Administrative Review Letter #19
Recipient Not Eligible

Date:

Provider name:
Provider address:
Provider city/state/zip

Re:
RID:
PA#:
Dates of service:

Dear Sir or Madam:

This is in response to your request for an administrative review of the decision made by Indiana Health Coverage Programs (IHCP) for the above-named member. The Indiana Administrative Code (IAC), 405 IAC 5-2-23, defines "Recipient" (Medicaid Recipient) as "an individual who has been determined by the office or the county office to be eligible for payment of medical or remedial services pursuant to IC 12-15." 405 IAC 5-3-7 states, "The provider assumes responsibility for verifying the recipient's eligibility on the service date."

The above-named member was not eligible for Indiana Medicaid on the requested date(s) of service. Therefore, your request for administrative review is being dismissed.

If you disagree with this determination, you have the right to appeal pursuant to 470 IAC 1-4. Your request must be filed in writing, within thirty (30) days, plus three (3) days mailing time, from the receipt of this letter, and mailed to the following address.

MS04
Indiana Family and Social Services Administration
Division of Family and Children
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Should you request reconsideration of this denial of administrative review, documentation must be presented showing that you or your office were given eligibility information that was incorrect.

Exhibit IV-19 – continued

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

(name and credentials of Specialist)
Prior Authorization Specialist
Indiana Medical Policy and Review Services

EXHIBIT IV-20

Administrative Review Letter #20
Untimely Prior Authorization Request

Date

Address

Re:
RID:
PA #:

Dear:

This is in response to your request for an Administrative Review for the above-named member. The Indiana Administrative Code (IAC) 405 IAC 5-3-8 states, "Except as provided in section 2 of this rule, prior to providing any Indiana Health Coverage Programs (IHCP) service that requires prior authorization, the provider must submit a properly completed IHCP prior review and authorization request and receive written notice indicating the approval for provision of such service." The rules also state, "It is the responsibility of the provider to submit new requests for prior authorization for ongoing services in a timely manner before the current authorization period expires in order to ensure that services are not interrupted."

The Indiana Administrative Code 405 IAC 5-3-9 provides the circumstances under which prior authorization will be given after services have begun or supplies have been delivered. These are: (1) pending or retroactive recipient eligibility. The prior authorization request must be submitted within twelve (12) months of the date of the issuance of the member's IHCP card. (2) Mechanical or administrative delays or errors by the contractor or county office of family and children. (3) Services rendered outside Indiana by a provider who has not yet received a provider manual. (4) Transportation services authorized under 405 IAC 5-30. The prior authorization request must be submitted within twelve (12) months of the date of service. (5) The provider was unaware that the member was eligible for services at the time services were rendered. Prior authorization will be granted in this situation only if the following conditions are met:

(A) The provider's records document that the member refused or was physically unable to provide the member identification (RID or IHCP) number.

(B) The provider can substantiate that the provider continually pursued reimbursement from the patient until IHCP eligibility was discovered.

(C) The provider submitted the request for prior authorization within sixty (60) days of the date IHCP eligibility was discovered.

Exhibit IV-20 – continued

The submitted records indicate the services were provided starting *(insert date)*. Prior authorization was not requested until *(insert date)*. There is no indication any of the exceptions listed in the Indiana Administrative Code have been met. Therefore, the previous denial is reaffirmed.

The Indiana Administrative Code, 405 IAC 5-7-1, stipulates that a member or provider may appeal the modification or denial of any IHCP covered service. After exhausting the Administrative Review remedies, a provider may request an Administrative Hearing.

Attached to the provider's request for hearing should be the following information:

1. A letter summarizing the requested service(s), the member's name, Member Identification Number (RID), and Prior Authorization number.

2. Documentation including any pertinent medical records, consultations, or other records to support the appellant's case (not previously submitted).

3. A copy of the Prior Authorization form, if applicable.

Based on 405 IAC 1.1-1-3, either request must be in writing and mailed to the following address within thirty (30) days, plus three (3) days mailing time, of the receipt of the Administrative Review decision.

MS04
Indiana Family and Social Services Administration
Division of Family and Children
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Director, Prior Authorization
Indiana Medical Policy and Review Services

EXHIBIT IV-21

Administrative Review Letter #21
Untimely Request for Administrative Review

Date

Address

Re:
RID:
PA #:
Dates of Service:

Dear:

Pursuant to 405 IAC 5-7-2, you have requested an administrative review of the prior authorization decision for the above-named recipient. This law states the request must be initiated within seven days (plus 3 days for mail) from the date the modification or denial is received by the provider or recipient.

Our records show this denial was made on *(insert date)*. Your request for administrative review was not received in our office until *(insert date)*. This exceeds the time limit as specified in the Indiana Administrative Code. Please note, the documentation received did not indicate this request met any of the criteria for retroactive authorization listed in 405 IAC 5-3-9.

Pursuant to 405 IAC 5-7-2(a), you may file an appeal of this decision under 405 IAC 1.1-1-3. Your appeal request must be filed in writing within thirty-three (33) days from the date on this letter. Please mail your appeal request to:

MSO4
Indiana Family and Social Services Administration
Division of Family and Children
402 West Washington Street, Room 392
Indianapolis, Indiana 46204
Attention: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Director, Prior Authorization
Indiana Medical Policy and Review Services

EXHIBIT IV-22

Administrative Review Letter # 22
Additional Information Required, Not Received, Original Decision Reaffirmed

Date

Address

Re:
RID:
PA #:
Date of Service:

Dear:

This is in response to your request for an Administrative Review for the above-named recipient. Our records show that the request for prior authorization was submitted within the designated time limitations. A decision could not be rendered based on the information provided. Additional information was requested. You were notified that thirty (30) days would be allowed for the submission of the requested information and that if the requested information was not received within the thirty (30) day limitation, the request would be denied.

Our records show this decision was made on *(insert date).* The decision letter was mailed to you and to the member on the following business day. The submitted information was received in our office *(insert date).* This surpasses the stated time limitation. Therefore, your request remains *denied/modified.*

The Indiana Administrative Code (IAC), 405 IAC 5-7-1, stipulates that a recipient or provider may appeal the modification or denial of any Medicaid covered service. After exhausting the Administrative Review remedies, a provider may request an Administrative Hearing.

Attached to the provider's request for hearing should be the following information:

1. A letter summarizing the requested service(s), the recipients name, Recipient Identification Number (RID) and Prior Authorization number.

2. Documentation including any pertinent medical records, consultations, or other records to support the appellant's case (not previously submitted)

3. A copy of the Prior Authorization form, if applicable.

Based on 405 IAC 1.1-1-3, either request must be in writing, and mailed to the following address within 33 days of the receipt of the Administrative Review decision.

EXHIBIT IV-22 – continued

MS04
Indiana Family and Social Services Administration
Division of Family and Children
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Director, Prior Authorization
Indiana Medical Policy and Review Services

EXHIBIT IV-23

Administrative Review Letter #23
Hospice Request Submitted Untimely

Date:

Address:

Re:
RID:
PA #:

Dear:

This is in response to your request for an Administrative Review for the above-named member. The Indiana Administrative Code (IAC) 405 IAC 5-34-4 (g) states, "In order to obtain authorization and reimbursement for hospice services, the provider must submit the documentation listed in this section to the office or its contractor within ten (10) business days of the effective date of the recipient's election, and within ten (10) business days of the beginning of the second and subsequent benefit periods if required under this section."

The Indiana Administrative Code 405 IAC 5-34-4 provides the circumstances under which prior authorization will be given after services have been furnished. These are:

1. Pending or retroactive recipient eligibility. The hospice authorization request must be submitted within twelve (12) months of the date of the issuance of the recipient's Medicaid card.

2. The provider was unaware that the recipient was eligible for services at the time services were rendered. Hospice authorization will be granted in this situation only if the following conditions are met:

    - the provider's records document that the member refused or was physically unable to provide the member identification number,
    - the provider can substantiate that the provider continually pursued reimbursement from the patient until IHCP eligibility was discovered,
    - and the provider submitted the request for prior authorization within sixty (60) days of the date IHCP eligibility was discovered.

The submitted records indicate the services were provided starting _____. Prior authorization was not requested until _____. There is no indication any of the exceptions listed in the Indiana Administrative Code have been met. Therefore, the previous denial is reaffirmed.

EXHIBIT IV-23 (Continued)

The Indiana Administrative Code, 405 IAC 5-7-1, stipulates that a member or provider may appeal the modification or denial of any IHCP covered service. After exhausting the Administrative Review remedies, a provider may request an Administrative Hearing.

Attached to the provider's request for hearing should be the following information:

1. A letter summarizing the requested service(s), the member's name, Member Identification Number (RID), and Prior Authorization number.

2. Documentation including any pertinent medical records, consultations, or other records to support the appellant's case (not previously submitted).

3. A copy of the Prior Authorization form, if applicable.

Based on 405 IAC 1.1-1-3, either request must be in writing and mailed to the following address within 33 days of the receipt of the Administrative Review decision.

MS04
Indiana Family and Social Services Administration
Division of Family and Children
402 W. Washington Street, Room W392
Indianapolis, IN 46204
Attn: Hearings and Appeals

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Sincerely,

Director, Prior Authorization
Indiana Medical Policy and Review Services

EXHIBIT IV-24

Administrative Review Letter #24
Hospice Administrative Review Request Received Untimely

Date

Address

Re:
RID:
PA #:
Date(s) of Service:

Dear:

Pursuant to Indiana Administrative Codes 405 IAC 5-7-2 and 405 IAC 5-34-4.1, you have requested an administrative review of the prior authorization decision for the above-named member. These laws state the request must be initiated within seven days (plus three days for mail) from the date the modification or denial is received by the provider or member.

Administrative review finds this denial was made on _____. Your request for administrative review was not received in our office until _____. This exceeds the time limit as specified in the Indiana Administrative Code.

Pursuant to 405 IAC 5-7-2(a), you may file an appeal of this decision under 405 IAC 1.1-1-3. Your appeal request must be filed in writing within thirty-three (33) days from the date on this letter. Please mail your appeal request to:

MSO4
Indiana Family and Social Services Administration
Division of Family and Children
402 West Washington Street, Room 392
Indianapolis, Indiana 46204
Attention: Hearings and Appeals

Thank you for your support of the Indiana Health Coverage Programs. If you have any questions, please call the Health Care Excel Prior Authorization Hearings and Appeals Department at (317) 347-4511.

Sincerely,

Director, Prior Authorization
Indiana Medical Policy and Review Services

EXHIBIT IV-25

LETTER OF RATIONALE

DATE:
RE:
RID:
PA#:

Dear Administrative Law Judge:

1. **ACTION(S) REQUESTED BY APPELLANT**

   (insert appropriate description)

2. **ACTION(S) / DECISION(S) TAKEN BY MEDICAID**

   (insert appropriate description)

3. **RATIONALE FOR ACTION(S) / DECISION(S) TAKEN BY MEDICAID**

   a. *Background description including eligibility information* (Exhibit #) [includes Face sheet, print of eligibility screen, print of prior authorization history screen]

   b. The submitted documentation indicates *further description as necessary* (Exhibit #)

   c. *further description as necessary* (Exhibit #)

   d. *further description as necessary* (Exhibit #)

   e. *further description as necessary* (Exhibit #)

   f. *further description as necessary* (Exhibit #)

Exhibit IV-25 (Continued)

LETTER OF RATIONALE

4. **SPECIFIC REGULATION(S) CITED FOR ACTION(S)/DECISION(S) TAKEN**

Indiana Medicaid Regulation 405 IAC 5-3-11 states: "The office's decision to authorize, modify, or deny a given request for prior authorization shall include consideration of the following:

- Individual case-by-case review of the completed Medicaid prior review and authorization request form;
- The medical and social information provided on the request form or documentation accompanying the request form;
- Review of criteria set out in this section for the service requested; and
- The medical necessity of the requested service based upon current professional standards commonly held to be applicable to the case."

42 CFR 440.230(d) states, "The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures."

Additional citations as appropriate to specific case

5. **SUMMARY**

We request the decision be upheld. The submitted documentation indicates *case specific rationale based on documentation cited in Section 3*

Sincerely,

(name and credentials of specialist)
Prior Authorization Specialist
Indiana Medical Policy and Review Services